NOTICE OF INDEPENDENT REVIEW DECISION

May 30, 2003 RE: MDR Tracking #: M2-02-0660-01 IRO Certificate #: IRO4326 has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed. The independent review was performed by a ____ physician reviewer who is board certified in physical medicine and rehabilitation is the same specialty as the treating physician. The ____ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ____ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case. Clinical History This patient sustained an injury on when pulling on some material and felt a sharp pain in his posterior right shoulder. His initial MRI report is unavailable but the patient states he was told he had a "tear". Per physical exam, the documentation states positive impingement syndrome and tendonitis. He has been treated with anti-inflammatories, physical therapy, and steroid injections. The patient's MRI from 04/01/02 revealed a supraspinatus tendinopathy and small intrasubstance tear with impingement. A right shoulder arthroscopy was performed in midMay 2002. Requested Service(s)

MRI

Decision

It is determined that the MRI was medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The second MRI was necessary to determine necessity for surgical interventions. The first MRI was nearly two years prior and likely did not reveal the impingement syndrome. The second MRI was necessary to direct the surgeon's approach and technique for intervention. Therefore, it is determined that the MRI was medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 30th day of May 2003.